FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0027482

Facility Name: Manorcare at Hinsdale

Address: 600 W. Ogden Ave. (Number) Hinsdale (City) 60521 (Zip Code)

County: Du Page

Telephone Number: (630)325-9630 **Fax #** (630)325-9648

IDPA ID Number: 520886946017

Date of Initial License for Current Owners: 11/01/81

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name Gary Geise **Telephone Number** (217)782-5731

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 06/01/99 to 05/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name) Barry Lazarus
(Title) V.P., Director of Reimbursement

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Print Preview

Facility Name & ID Number Manorcare at Hinsdale # 0027482 Report Period Beginning: 06/01/99 Ending: 05/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	200	Skilled (SNF)	200	73,200	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	200	TOTALS	200	73,200	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	5,471	3,331	9,284	18,086	8
9	SNF/PED					9
10	ICF	4,030	40,286	1,506	45,822	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,501	43,617	10,790	63,908	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4 87.31%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Day Care

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/01/81

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/01/81 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 57 and days of care provided 7233

Medicare Intermediary Blue Cross of Maryland

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [X]

Tax Year: 12/31/00 Fiscal Year: 5/31/00

* All facilities other than governmental must report on the accrual basis.

Print Preview

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number Manorcare at Hinsdale # 0027482 **Report Period Beginning:** 06/01/99 **Ending:** 05/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	445,942	46,632	713	493,287	1,576	494,863	0	494,863			1
2	Food Purchase		296,745		296,745		296,745	(766)	295,979			2
3	Housekeeping	170,591	21,858	3,001	195,450		195,450	0	195,450			3
4	Laundry	50,914	30,462	1,546	82,922		82,922	0	82,922			4
5	Heat and Other Utilities			231,891	231,891	18,716	250,607	0	250,607			5
6	Maintenance	44,103	69,967	45,517	159,587		159,587	0	159,587			6
7	Other (specify):*							0				7
8	**TOTAL General Services**	711,550	465,664	282,668	1,459,882	20,292	1,480,174	(766)	1,479,408			8
	B. Health Care and Programs											
9	Medical Director			16,500	16,500		16,500	0	16,500			9
10	Nursing and Medical Records	2,923,292	324,778	13,771	3,261,841	25,338	3,287,179	(3,107)	3,284,072			10
10a	Therapy	323,821	11,297	67,478	402,596		402,596	0	402,596			10a
11	Activities	139,514	1,307	7,788	148,609		148,609	0	148,609			11
12	Social Services	83,940	1		83,941		83,941	0	83,941			12
13	Nurse Aide Training							0				13
14	Program Transportation							0				14
15	Other (specify):*							0				15
16	**TOTAL Health Care and Progra**	3,470,567	337,383	105,537	3,913,487	25,338	3,938,825	(3,107)	3,935,718			16
	C. General Administration											
17	Administrative	116,260		542,634	658,894	(216,374)	442,520	0	442,520			17
18	Directors Fees							0				18
19	Professional Services			7,636	7,636	(7,636)		0				19
20	Dues, Fees, Subscriptions & Promotions			52,288	52,288		52,288	(21,579)	30,709			20
21	Clerical & General Office Expense	286,197	37,141	129,290	452,628	7,636	460,264	(52,864)	407,400			21
22	Employee Benefits & Payroll Taxes			778,741	778,741	2,110	780,851	0	780,851			22
23	Inservice Training & Education			5,144	5,144		5,144	0	5,144			23
24	Travel and Seminar			9,421	9,421		9,421	0	9,421			24
25	Other Admin. Staff Transportation							0				25
26	Insurance-Prop.Liab.Malpractice			161,145	161,145		161,145	0	161,145			26
27	Other (specify): **Person Purchases**			7,759	7,759		7,759	(7,759)				27
28	**TOTAL General Administration**	402,457	37,141	1,694,058	2,133,656	(214,264)	1,919,392	(82,202)	1,837,190			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,584,574	840,188	2,082,263	7,507,025	(168,634)	7,338,391	(86,075)	7,252,316			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Print Preview

IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number Manorcare at Hinsdale # 0027482 Report Period Beginning: 06/01/99 Ending: 05/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger: Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			570,557	570,557	32,316	602,873	(103,140)	499,733			30
31	Amortization of Pre-Op. & Org.							0				31
32	Interest			621	621	136,318	136,939	(621)	136,318			32
33	Real Estate Taxes			111,989	111,989		111,989	0	111,989			33
34	Rent-Facility & Grounds							0				34
35	Rent-Equipment & Vehicles			40,759	40,759		40,759	0	40,759			35
36	Other (specify):*							0				36
37	TOTAL Ownership			723,926	723,926	168,634	892,560	(103,761)	788,799			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers		256,053	12,981	269,034		269,034	0	269,034			39
40	Barber and Beauty Shops		19,278		19,278		19,278	0	19,278			40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee			109,800	109,800		109,800	0	109,800			42
43	Other (specify):* IV Drugs		99,065		99,065		99,065	0	99,065			43
44	TOTAL Special Cost Centers		374,396	122,781	497,177		497,177		497,177			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,584,574	1,214,584	2,928,970	8,728,128	0	8,728,128	(189,836)	8,538,292			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

Print Preview

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number Manorcare at Hinsdale # 0027482 Report Period Beginning: 06/01/99 Ending: 05/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$ (3,107)	10	$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(766)	2		4
5	Telephone, TV & Radio in Resident Rooms	(8,428)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(103,140)	30		9
10	Interest and Other Investment Income	(621)	32		10
11	Discounts, Allowances, Rebates & Refunds	(28)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,025)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(7,759)	27		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(1,250)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(29,597)	21		24
25	Fund Raising, Advertising and Promotional	(21,579)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Vending Inc. & Misc.	(11,536)	21		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (189,836)		$	30

OHF USE ONLY								
48		49		50		51	52	

B. If there are expenses experienced by the facility which do not appear in th general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (189,836)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Print Preview

ıe

Detail lines 29 and 35 of Page 5 starting in B44 DO NOT DRAG AND DROP CELLS.
The amounts in columns F will transfer to the Adj. Summary column automatically.
The amounts in the Adj. Summary column are linked to pages Summary A and B.

To Print the Other Adjustments you have entered.
1. **Highlight the other adjustments you have entered starting at B44 and continue to your last entry. Be sure the columns highlighted are B thru G.**
2. **Push the Print Other Adjustments button.**

Print Other

STATE OF ILLINOIS **Page 5A**

Facility Name Manorcare at Hinsdale
IDH 0027482
Report Period Beginning: 06/01/99
Ending: 05/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	Sch V	Adj. Summary
	The information listed in B13 thru G43 is from Page 5.			**Line 1**	0
1	**Day Care**	(3,107)	10	**Line 2**	(782)
2	**Other Care for Outpatients**	0	0	**Line 3**	0
3	**Governmental Sponsored Special Programs**	0	0	**Line 4**	0
4	**Non-Patient Meals**	(766)	2	**Line 5**	0
5	**Telephone, TV & Radio in Resident Rooms**	(8,428)	21	**Line 6**	0
6	**Rented Facility Space**	0	0	**Line 7**	0
7	**Sale of Supplies to Non-Patients**	0	0	**Line 8**	(782)
8	**Laundry for Non-Patients**	0	0	**Line 9**	0
9	**Non-Straightline Depreciation**	(103,140)	30	**Line 10**	(5,107)
10	**Interest and Other Investment Income**	(621)	32	**Line 10a**	0
11	**Discounts, Allowances, Rebates & Refunds**	(28)	21	**Line 11**	0
12	**Non-Working Officer's or Owner's Salary**	0	0	**Line 12**	0
13	**Sales Tax**	(2,025)	21	**Line 13**	0
14	**Non-Care Related Interest**	0	0	**Line 14**	0
15	**Non-Care Related Owner's Transactions**	0	0	**Line 15**	0
16	**Personal Expenses (Including Transportation)**	(7,759)	27	**Line 16**	(5,107)
17	**Non-Care Related Fees**	0	0	**Line 17**	0
18	**Fines and Penalties**	0	0	**Line 18**	0
19	**Entertainment**	0	0	**Line 19**	0
20	**Contributions**	(1,250)	21	**Line 20**	(21,579)
21	**Owner or Key-Man Insurance**	0	0	**Line 21**	(81,772)
22	**Special Legal Fees & Legal Retainers**	0	0	**Line 22**	0
23	**Malpractice Insurance for Individuals**	0	0	**Line 23**	0
24	**Bad Debt**	(29,597)	21	**Line 24**	0
25	**Fund Raising, Advertising and Promotional**	(21,579)	20	**Line 25**	0
26	**Income & IL Personal Property Replacement T**	0	0	**Line 26**	0
27	**Nurse Aide Training for Non-Employees**	0	0	**Line 27**	(9,735)
28	**Yellow Page Advertising**	0	0	**Line 28**	(70,666)
29	**Non-Paid Workers**	0	0	**Line 29**	(74,340)
30	**Donated Goods**	0	0	**Line 30**	(103,140)
31	**Amortization Expense**	0	0	**Line 31**	0
				Line 32	(621)
				Line 33	0
				Line 34	0
				Line 35	0
				Line 36	0
				Line 37	(103,761)
				Line 38	0
				Line 39	0
				Line 40	0
				Line 41	0
				Line 42	0
				Line 43	0
				Line 44	0
				Line 45	(179,109)

Reference 1	Reference 2	Reference 3	Reference 4	Reference 5	Reference 6	Reference 7	Reference 9	Reference 10	Reference 10a	Reference 11	Reference 12	Reference 13	Reference 14	Reference 15	Reference 17	Reference 18	Reference 19	Reference 20	Reference 21	Reference 22	Reference 23	Reference 24	Reference 25	Reference 26	Reference 27	Reference 30	Reference 31	Reference 32	Reference 33	Reference 34	Reference 35	Reference 36	Reference 38	Reference 39	Reference 40	Reference 41	Reference 42	Reference 43

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Summary A

Facility Name & ID Numb Manorcare at Hinsdale # 0027482 Report Period Beginning: 06/01/99 Ending: 05/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary A

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(766)	0	0	0	0	0	0	0	0	0	0	(766)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(766)	0	0	0	0	0	0	0	0	0	0	(766)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(3,107)	0	0	0	0	0	0	0	0	0	0	(3,107)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Program**	(3,107)	0	0	0	0	0	0	0	0	0	0	(3,107)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(21,579)	0	0	0	0	0	0	0	0	0	0	(21,579)	20
21	Clerical & General Office Expenses	(41,328)	0	0	0	0	0	0	0	0	0	0	(41,328)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(7,759)	0	0	0	0	0	0	0	0	0	0	(7,759)	27
28	**TOTAL General Administration**	(70,666)	0	0	0	0	0	0	0	0	0	0	(70,666)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(74,539)	0	0	0	0	0	0	0	0	0	0	(74,539)	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary B

Facility Name & ID Numb: Manorcare at Hinsdale # 0027482 Report Period Beginning: 06/01/99 Ending: 05/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary B

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(103,140)	0	0	0	0	0	0	0	0	0	0	(103,140)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(621)	0	0	0	0	0	0	0	0	0	0	(621)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(103,761)	0	0	0	0	0	0	0	0	0	0	(103,761)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Cent**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(178,300)	0	0	0	0	0	0	0	0	0	0	(178,300)	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Numbe Manorcare at Hinsdale # 0027482 Report Period Beginning 06/01/99 Ending: 05/31/00

Show Pgs 6A thru 6 | Show Pgs 6E thru 6I | Hide Pgs 6A thru 6I

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
ManorCare Inc.	100	Health Care & Retirement Corporation of America	Toledo, OH			
		(SEE H.O. COST REPORT)				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	See Page 1 Home Office Allocation	$ 542,624	HCR Manorcare, Inc	100.00%	$ 542,624	$	1
2	V	9						2
3	V							3
4	V							4
5	V							5
6	V	10a Therapy Management	28,420	Heartland Management Services	100.00%	28,420		6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		$ 571,054			$ 571,054	$ *	14

Sum_6

* Total must agree with the amount recorded on line 34 of Schedule V

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

Print Preview

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Line 1 Line 2 Line 3 Line 4 Line 5 Line 6 Line 7 Line 9 Line 10 Line 10a Line 11 Line 12 Line 13 Line 14 Line 15 Line 17 Line 18 Line 19 Line 20 Line 21 Line 22 Line 23 Line 24 Line 25 Line 26 Line 27 Line 30 Line 31 Line 32 Line 33 Line 34 Line 35 Line 36 Line 38 Line 39 Line 40 Line 41 Line 42 Line 43

Facility Name & ID Number Manorcare at Hinsdale # 0027482 Report Period Beginnin 06/01/99 Ending: 05/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REI

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Print Preview

the name(s)
PORTS.

Facility Name & ID Number Manorcare at Hinsdale # 0027482 Report Period Beginning: 06/01/99 Ending: 05/31/00

VIII. ALLOCATION OF INDIRECT C... Show Pgs 8A thru 8D | Show Pgs 8E thru 8I | Hide Pgs 8A thru 8I

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organizatio: HCR ManorCare, Inc.
Street Address: 333 N. Summit St.
City / State / Zip Code: Toledo, OH 43604-2617
Phone Number: (419) 252-5500
Fax Number: (419) 254-5495

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Accumulated Cost	#########	357 Nurs.Fac.	$ 388,478	$ 221,496	406,316	$ 1,576	1
2	5	Utilities	Accumulated Cost	#########	357 Nurs.Fac.	4,614,666		406,316	18,716	2
3	10	Nursing	Accumulated Cost	#########	357 Nurs.Fac.	6,247,503	4,177,723	406,316	25,338	3
4	17	General & Administrative	Accumulated Cost	#########	357 Nurs.Fac.	80,443,795	26,746,978	406,316	326,260	4
5	22	Employee Benefits	Accumulated Cost	#########	357 Nurs.Fac.	520,233		406,316	2,110	5
6	30	Depreciation	Accumulated Cost	#########	357 Nurs.Fac.	7,968,019		406,316	32,316	6
7	32	Interest	Direct Cost	1	1	136,318		1	136,318	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 100,319,012	$ 31,146,197		$ 542,634	25

Print Preview

Facility Name & ID Number Manorcare at Hinsdale # 0027482 Report Period Beginning: 06/01/99 Ending: 05/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Conv. Sub. Debentures		X	Facility			$ 4,305,633	$ 4,305,633			$ 136,318	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 4,305,633	$ 4,305,633			$ 136,318	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 4,305,633	$ 4,305,633			$ 136,318	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Print Preview

Facility Name & ID Numbe Manorcare at Hinsdale # 0027482 Report Period Beginning: 06/01/99 Ending: 05/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	129,120	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	120,916	2
3. Under or (over) accrual (line 2 minus line 1).	$	(8,204)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	120,193	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	111,989	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	117,456	8
	1996	114,570	9
	1997	120,040	10
	1998	122,972	11
	1999	118,860	12

Line 2 = $61,486 for '98 + $59,430 for '99.

Line 4 = $59,430 (2nd 1/2 of $118,860) for Jul.-Dec. 1999 + $50,516 for Jan.-May 2000 + $10,247 Adjustment for prior ye

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATIC	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**

This denial must be no more than four years old at the time the cost report is filed.

Print Preview

Facility Name & ID Numb Manorcare at Hinsdale # 0027482 Report Period Beginning: 06/01/99 Ending: 05/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 49,441 B. General Construction Type: Exterior Masonary Frame Steel Number of Stories 3

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility			$ 1,358,110	1
2					2
3	TOTALS			$ 1,358,110	3

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12B | Show Pgs 12C and 12D | Hide Pgs 12A thru 12D

STATE OF ILLINOIS

Facility Name & ID Number Manorcare at Hinsdale # 0027482 Report Period Beginning: 06/01/99 Ending: 05/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	100		1972		$ 1,160,300	$ 83,577		$ 83,577	$	$ 1,617,669	4
5	100			1980	1,913,000						5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	Current Year Depreciation					260,447		260,447		1,336,321	9
10				1984	4,367						10
11				1985	6,383						11
12				1987	107,721						12
13				1988	22,849						13
14				1989	173,344						14
15				1990	114,281						15
16				1991	240,682						16
17				1992	131,037						17
18				1993	421,420						18
19				1994	145,930						19
20				1995	182,224						20
21	WALLVINYL			1996	18,252						21
22	FLOORING/SHEET VINYL			1996	20,990						22
23	HANDRAILS			1996	2,746						23
24	ROOF WORK			1996	7,756						24
25	INSTALL DOORS/HARDWARE			1996	10,900						25
26	CARPET			1996	14,303						26
27	PLUMBING			1996	3,627						27
28	CAPITALIZED LABOR			1996	7,272						28
29	BASE BOARDS			1996	1,768						29
30	SIGNS			1996	1,715						30
31	ELECTRICAL/LIGHTING			1996	32,949						31
32	REMODEL/DECORATE			1996	35,484						32
33	CALIBRATE VAV BOXES			1996	5,000						33
34	HVAC			1996	2,246						34
35	PROFESSIONAL FEES/PERMIT			1996	3,723						35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 344,024		$ 344,024	$	$ 2,953,990	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12A

STATE OF ILLINOIS

Facility Name & ID Numbe Manorcare at Hinsdale # 0027482 Report Period Beginning: 06/01/99 Ending: 05/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	HVAC SYSTEM/HUMIDIFIER/THERMOSTAT			1996	35,753						9
10	BASEMENT DOOR			1996	1,824						10
11	CARPET			1996	16,641						11
12	ELECTRICAL/LIGHTING/WIRING			1996	4,351						12
13	DOORS/LOCKS			1996	2,245						13
14	WALLCOVERINGS			1996	7,726						14
15	INSTALL CABINETRY			1996	3,952						15
16	REMODELING			1996	8,296						16
17	CEILING REPAIRS/PAINTING			1996	12,905						17
18	REPAIR/REPLACE WALLS			1996	4,713						18
19	REDO WALK-IN DOORS			1996	3,048						19
20	KITCHEN WORK/PLUMBING			1996	2,305						20
21	ASPHALT/PAVING/BRICK WORK			1996	61,400						21
22	WALLCOVERINGS			1997	19,650						22
23	CARPET			1997	21,361						23
24	WALL GUARDS/DRYWALL			1997	2,699						24
25	REPLACE HOT WATER HEATER			1997	9,995						25
26	REMOVE EXHAUST DUCTS			1997	7,851						26
27	INSTALL CABINETS			1997	4,815						27
28	DECORATING			1997	5,893						28
29	CURB ELIMINATIONS			1997	95,648						29
30	TILE & INSTALLATION			1997	8,449						30
31	AIR COMPRESSOR SYSTEM			1997	23,972						31
32	REMOVE & INSTALL DOORS			1997	17,754						32
33	RENOVATE DINING & ACTIVITY ROOM			1997	6,159						33
34	ROOFTOP A/C CONDENSOR			1997	20,861						34
35	LIGHTING/ELECTRIC			1997	27,913						35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12B

STATE OF ILLINOIS

Facility Name & ID Numbe Manorcare at Hinsdale # 0027482 Report Period Beginning: 06/01/99 Ending: 05/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	BATHROOM REMODELING			1997	9,704						9
10	HVAC			1997	7,754						10
11	SHOWER ROOM			1997	23,558						11
12	PLUMBING			1997	2,684						12
13	SECURITY/PATIO DOOR			1997	2,087						13
14	REMODELING/CONSTRUCTION			1997	8,223						14
15	MASONRY			1997	5,980						15
16	INSTALL AUDIO SYSTEM			1997	1,555						16
17	CONCRETE WORK			1997	9,761						17
18	CORPORATE OVERHEAD			1997	10,516						18
19	RETIREMENTS			1987	(93,514)						19
20	RETIREMENTS			1992	(19,287)						20
21	RETIREMENTS - REMODELING/CONSTRUCTION			1997	(76)						21
22	RETIREMENTS - PLUMBING			1997	(2,684)						22
23	RETIREMENTS - MASONRY			1997	(5,980)						23
24	HVAC WORK			1997	18,444						24
25	FACILITY PLAN ALLOC			1997	5,964						25
26	INSTALL WATER SOFTNER			1997	9,006						26
27	INSTALL HANDRAILS & CORNER GUARDS			1997	8,206						27
28	DRYWALL - LAUNDRY ROOM REHAB			1997	1,425						28
29	SECURITY CAMERA			1997	1,327						29
30	CARPENTRY - DIETARY OFFICE			1997	6,545						30
31	AIR HANDLER/CONTROL SYSTEM			1997	15,744						31
32	PLAN REVIEW FEES			1997	2,700						32
33	CONSULTING FEES			1997	2,685						33
34	FIRE CEILING/SPRINKLER HEADS			1997	1,599						34
35	INSTALL LIGHT POLES			1997	4,026						35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12C

STATE OF ILLINOIS

Facility Name & ID Numbe Manorcare at Hinsdale # 0027482 Report Period Beginning: 06/01/99 Ending: 05/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	HVAC WORK			1998	33,527						9
10	DOORS & FRAMES			1998	15,727						10
11	INSTALL CEILING TILES			1998	5,588						11
12	INSTALL LIGHT FIXTURES/SIGNS			1998	12,000						12
13	ELECTRICAL			1998	2,651						13
14	REMOVE & INSTALL HANDRAILS			1998	9,572						14
15	REMOVE & INSTALL CABINETS			1998	8,842						15
16	CARPET			1998	10,033						16
17	WALLCOVERINGS			1998	18,660						17
18	CORPORATE OVERHEAD			1998	1,651						18
19	GENERAL CONTRACTOR FEES			1998	16,944						19
20	FINISH STUD			1998	3,917						20
21	SPRINKLER SYSTEM			1998	338						21
22	LANDSCAPING			1998	6,200						22
23	DRAINAGE TILE			1998	2,628						23
24	SITE DEMOLITION			1998	2,305						24
25	PROFESSIONAL FEES			1998	1,178						25
26	PLUMBING			1998	58,714						26
27	ELECTRICAL			1998	39,658						27
28	DEVELOPERS			1998	5,568						28
29	FLOORING/CEILING			1998	27,835						29
30	HVAC			1998	45,763						30
31	DOOR/WINDOW			1998	2,217						31
32	SIGN			1998	13,274						32
33	CARPENTRY			1998	26,696						33
34	MILLWORK			1998	5,787						34
35	FINISH STUDS			1998	9,945						35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12D

STATE OF ILLINOIS

Facility Name & ID Numbe Manorcare at Hinsdale # 0027482 Report Period Beginning: 06/01/99 Ending: 05/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	GEN.REQU.			1998	6,719						9
10	PAINTING/WALLCOVERING			1999	8,805						10
11	PLUMBING/PUMPS			1999	4,890						11
12	ELECTRICAL			1999	1,294						12
13	FLOORING - CARPET/TILE			1999	24,622						13
14	HVAC			1999	990						14
15	DOORS/WINDOWS			1999	28,233						15
16	HAND RAILS			1999	1,813						16
17	BATH ROOM RENOVATIONS			1999	7,880						17
18	WATER SEEPAGE REPAIRS			1999	13,566						18
19	SPRINKLER SYSTEM			1999	1,390						19
20	ART WORK/DECROATIONS			1999	5,842						20
21	SIDEWALK			1999	7,815						21
22	ELECTRICAL			2000	5,331						22
23	CARPET & PAINTING			2000	59,071						23
24	FLOORING - CARPET/TILE			2000	8,354						24
25	HVAC			2000	25,914						25
26	DOORS/WINDOWS			2000	10,900						26
27	ROOFING			2000	975						27
28	SAFEY GUARDS, RAILS, & GATES			2000	4,009						28
29	FIRE PROTECTION-SPRINKLERS & SMOKE DAMPERS			2000	16,350						29
30	RETIREMENTS			2000	(189,919)						30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

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Facility Name & ID Number Manorcare at Hinsdale # 0027482 Report Period Beginning: 06/01/99 Ending: 05/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Componen Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 958,128	$ 123,393	$ 123,393	$		$ 681,645	37
38	Current Year Purchases	122,438						38
39	Fully Depreciated Assets	(119,833)					(119,502)	39
40	Home Office Allocation			32,316	32,316			40
41	TOTALS	$ 960,733	$ 123,393	$ 155,709	$ 32,316		$ 562,143	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ #VALUE!	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 467,417	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 499,733	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 32,316	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 3,516,133	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	STEP-UP BUILDING	$ 3,713,060	$ 103,140	$ 1,916,695	52
53					53
54					54
55					55
56					56
57	TOTALS	$ 3,713,060	$ 103,140	$ 1,916,695	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

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XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the curre rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipm $ 40,759 Description: 02 Concentrators, Wheelchairs, Gerichairs, Elect. Beds, etc.
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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Facility Name & ID Number Manorcare at Hinsdale # 0027482 Report Period Beginning: 06/01/99 Ending: 05/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income y facility received training aides from other faciliti

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

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Facility Name & ID Number Manorcare at Hinsdale # 0027482 Report Period Beginning: 06/01/99 Ending: 05/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a	710	hrs	$ 19,472		$	$ 1,266	710	$ 20,738	1
2	Licensed Speech and Language Development Therapist	10a	995	hrs	32,844	36	900	6,821	1,031	40,565	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a	3,296	hrs	84,896	20	483	3,210	3,316	88,589	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	39,2		# of prescrpts				256,053		256,053	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Exceptional Care Program										12
13	Other (specify): X-Ray & Lab	39,3					12,981			12,981	13
14	TOTAL				$ 137,212	56	$ 14,364	$ 267,350	5,057	$ 418,926	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

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Facility Name & ID Number Manorcare at Hinsdale # 0027482 Report Period Beginning: 06/01/99 Ending: 05/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 05/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 43,024	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 308,738)	1,198,377		3
4	Supply Inventory (priced at)	28,759		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	4,818		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,274,978	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,358,110		13
14	Buildings, at Historical Cost	9,423,522		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	960,733		16
17	Accumulated Depreciation (book methods)	(5,432,826)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	(276)		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 6,309,263	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,584,241	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 93,710	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	142,840		30
31	Accrued Taxes Payable (excluding real estate taxes)	35,322		31
32	Accrued Real Estate Taxes(Sch.IX-B)	109,946		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accured Trade Paybles & Liabilities	46,838		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 428,656	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 428,656	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 7,155,585	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 7,584,241	$	48

***(See instructions.)**

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Facility Name & ID Number Manorcare at Hinsdale # 0027482 Report Period Beginning: 06/01/99 Ending: 05/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 19,016,884	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 19,016,884	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,503,308	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 2,503,308	17
	B. Transfers (Itemize):		
18	**Change in Interdivision**	(14,364,607)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (14,364,607)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 7,155,585	24 *

*** This must agree with page 17, line 47.**

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Facility Name & ID Number Manorcare at Hinsdale # 0027482 Report Period Beginning: 06/01/99 Ending: 05/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 11,363,607	1
2	Discounts and Allowances for all Levels	(1,692,913)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,670,694	3
	B. Ancillary Revenue		
4	Day Care	3,107	4
5	Other Care for Outpatients		5
6	Therapy	1,166,156	6
7	Oxygen	27,044	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,196,307	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	14,154	12
13	Barber and Beauty Care	31,973	13
14	Non-Patient Meals	766	14
15	Telephone, Television and Radio	8,428	15
16	Rental of Facility Space		16
17	Sale of Drugs	242,504	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	11,037	19
20	Radiology and X-Ray	1,195	20
21	Other Medical Services		21
22	Laundry	32,374	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thr**	$ 342,431	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and**	$	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Misc. $9,287 & Purch. Discounts $28**	9,240	28
28a	**Late Charges**	12,764	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 22,004	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 2**	$ 11,231,436	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	$ 1,459,882	31
32	Health Care	3,913,487	32
33	General Administration	2,133,656	33
	B. Capital Expense		
34	Ownership	723,926	34
	C. Ancillary Expense		
35	Special Cost Centers	387,377	35
36	Provider Participation Fee	109,800	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,728,128	40
41	**Income before Income Taxes (line 30 minus line 40)****	2,503,308	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus**	$ 2,503,308	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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